For use ***only*** when submitting a change.

DELTA DENTAL®

Delta Dental of Wisconsin

State of Wisconsin – ETF

Supplemental Dental Retiree/Continuant Change Form

Please note that completing this form does not guarantee coverage

COMPLETE THIS SECTION IF YOU ARE ACCEPTING COVERAGE

SUBSCRIBER LAST NAME	FIRST	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH M/D/Y	GENDER F M
				/ /	☐ ☐

HOME ADDRESS – STREET	CITY	STATE	ZIP

DATE OF HIRE	PHONE NUMBER
/ /	

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

LAST NAME (IF DIFFERENT)	FIRST	M.I.	GENDER F	GENDER M	DATE OF BIRTH M/D/Y
SPOUSE			☐	☐	/ /
CHILD/DEPENDENT			☐	☐	/ /
			☐	☐	/ /
			☐	☐	/ /
			☐	☐	/ /
			☐	☐	/ /
			☐	☐	/ /

REASON FOR SUBMITTING THIS FORM

	Date Occurred
☐ Birth/Adoption (Name: _____)	/ /
☐ Marriage/ ☐ Divorce	/ /
☐ Add/ ☐ Drop Dependent (Name: _____)	/ /
☐ Termination of Benefits (Reason: _____)	/ /
☐ Loss of Dental Benefits	/ /
☐ Name Change (Former Name: _____)	/ /
☐ Address Change (_____)	/ /

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

Preventive Plan (if not enrolled in health plan)

☐ Self Only ☐ Entire Family

Select or Select Plus Plan

☐ Self Only ☐ Self & Spouse

☐ Self & Child(ren) ☐ Entire Family

PLAN SELECTION (Choose Preventive Plan and/or the Select or Select Plus Plan)**:**

☐ Delta Dental PPO Plus Premier™ – Preventive Plan (option only available if **not** enrolling in health plan)

☐ Delta Dental PPO™ – Select Plan

☐ Delta Dental PPO Plus Premier™ – Select Plus Plan

BILLING

HOW WOULD YOU LIKE TO BE BILLED?

☐ **Auto Pay:** Set up monthly payment from your saving or checking account. Payments will be drawn on the fifth of each month.

Name of Financial Institution _____

Type of Account (Choose one) ☐ Checking ☐ Savings

Bank Routing Number _____

Bank Account Number _____

In addition, Please attach a voided check

By checking Auto Pay above I hereby authorize Delta Dental of Wisconsin to initiate debit entries on my account and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account and the financial institution I have indicated above. The authority is to remain in full force and effect until Delta Dental of Wisconsin has received written notification from me of its termination in such time and in such manner to afford Delta Dental of Wisconsin and my financial institution a reasonable opportunity to act upon it.

☐ **Bill Me:** Receive a paper invoice monthly and pay by check. Paper invoices are mailed each month on the fifteenth with payment due on the first.

☐ **ACCEPT COVERAGE**

X _____ / /

Signature is Required Date

Return To:
Delta Dental of Wisconsin P.O. Box 828 Stevens Point, WI 54481
Phone: 844-337-8383